Helpful Information Book

January 1 - December 31, 2014

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2014 Plan Year

Jan. 1 - Dec. 31

NOTICE

HEALTH CARE SERVICES MAY BE PROVIDED TO YOU AT A NETWORK HEALTH CARE FACILITY BY FACILITY-BASED PHYSICIANS WHO ARE NOT IN YOUR HEALTH PLAN. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE OUT-OF-NETWORK SERVICES, IN ADDITION TO APPLICABLE AMOUNTS DUE FOR CO-PAYMENTS, COINSURANCE, DEDUCTIBLES, AND NON-COVERED SERVICES.

SPECIFIC INFORMATION ABOUT IN-NETWORK AND OUT-OF-NETWORK FACILITY-BASED PHYSICIANS CAN BE FOUND AT YOUR HEALTH PLAN'S WEBSITE OR CUSTOMER SERVICE LINE.

Who is Eligible for Coverage?

Full-time employees of a participating agency or school board (as defined by a participant employer in accordance with state law) are eligible for the Office of Group Benefits program. Employees working on temporary appointments are not considered full-time employees.

DEPENDENTS
The following people can be enrolled as dependents:

A. Your legal spouse
B. Your children until they reach age 26. (Coverage ends the last day of their birthday month.)

Reminder
You must provide appropriate documents to OGB to verify eligibility of all covered dependents.

The term children includes the following:

- Natural child of employee or legal spouse – until age 26
- Legally adopted child – until age 26
- Child placed in employee's home for adoption – until age 26
- Child in employee's home under legal guardianship or custody. A grandchild whose parent is a covered dependent or for whom employee has legal guardianship or custody.

Military Reserve Members
Certain provisions have been made for military reserve members.

If you are on active military duty, consult your Plan Document for specific eligibility criteria and required documentation.

Effective Date of Coverage for New Hires and Transfers
The effective date of coverage for new hires whose employment begins on the first of the month will be the first day of the following month. If employment begins on the second day of the month or later, coverage is effective the first day of the next month after 30 days of employment. An employee who transfers employment should complete a transfer form within 30 days.

Example:	If employment begins:	Coverage begins:
	September 1	**October 1**
	If employment begins:	Coverage begins:
	September 2	**November 1**

Overdue Applicants (also referred to as Late Applicants)
The effective date of coverage for overdue applicants whose forms are received prior to the 15th of the month will be the first day of the month following the date of receipt by OGB of all required forms. The effective date of coverage for overdue applicants whose forms are received on or after the 15th of the month will be the first day of the second month following receipt.

Overdue applicants are employees who apply for coverage more than 30 days after starting employment or dependents who are not added within 30 days of becoming eligible.

Retirees cannot obtain coverage as overdue applicants. *Dependents of retirees, however, can obtain coverage as overdue applicants.*

Dependent Verification

All plan members must provide certified documents to their agency to verify their legal relationship to each dependent to be covered within 30 days of the date of application for coverage. Once the agency has seen the certified documents a copy must then be sent to OGB so the dependent can be verified in the OGB system.

The plan will accept a birth letter or birth card as verification for newborns for up to 6 months to allow time to get the birth certificate. If the birth certificate has not been received by OGB at the end of six months, benefits for that dependent child will be terminated and future coverage will be considered as a late applicant.

Over-Age Dependents (Continued Coverage)

A covered child under age 26 who is or becomes incapable of self-sustaining employment is eligible to continue coverage as an over-age dependent if OGB receives the required medical documents verifying the child's incapacity before he or she reaches age 26.

See Plan Document for documentation required to establish eligibility.

Coverage for Retirees

To be eligible for retiree coverage, your coverage must be in effect immediately prior to your retirement. For those beginning participation or rejoining on or after January 1, 2002, the state subsidy of your premium is based on the number of years you have participated in a Group Benefits health plan. This also applies to surviving dependents who begin coverage after July 1, 2002.

Retiree Participation Schedule	
Years of Participation	**Percentage of State Subsidy**
Less than 10 years	19%
10 years or more, but less than 15 years	38%
15 years or more, but less than 20 years	56%
20 years or more	75%

The Participation Schedule is the timeline showing the number of years you must participate in an OGB health plan to receive a specific premium subsidy from the state.

Retirees Returning to Work (Re-employed Retirees)
Whenever a retiree with OGB health and life coverage returns to full-time employment with the state, the retiree is placed in the "re-employed retiree" category for premium calculation. The re-employed retiree premium classification applies to retirees both with and without Medicare. The premium rates applicable to the re-employed retiree premium classification are identical to the premium rates for the "retirees with no Medicare" classification.

The agency hiring a retired OGB plan member is required to notify OGB. OGB will determine whether OGB coverage is primary or secondary, and notify the agency of the change in status.

It is the responsibility of the retiree returning to work to inform the hiring agency that they are retired from another agency with OGB coverage.

Effective January 1, 2014

OGB Medical Benefits Comparison for Active

COVERED BENEFIT: IN-NETWORK	**PPO Plan (nationwide)** *Administered by Blue Cross and Blue Shield of La.*	**HMO Plan (nationwide)** *Administered by Blue Cross and Blue Shield*
Lifetime Maximum Benefit (all eligible expenses)	Unlimited	Unlimited
Plan Year Deductible - Employees and Dependents	$500 active; $300 retired Family unit maximum: 3 individual deductibles	None
Maximum Out-Pocket Expense In-Network	» $1000 per person » $12,700 per family	» $1000 per person » $3000 per family
Hospital Services - Inpatient	Member pays 10% of contracted rate [1, 2]	$100 per day [2]; $300 maximum per admi
Surgeon, Anesthesia, Lab, X-rays & Injections	Member pays 10% of contracted rate [1]	$0 co-payment
Hospital Emergency Room (facility only)	$150 separate deductible; waived if admitted Member pays 10% of contracted rate [1]	$100 co-payment; waived if admitted (hospital co-payment applies)[2]
Ambulatory Surgical Facilities	Member pays 10% of contracted rate [1]	$100 co-payment
Physician Visits	Member pays 10% of contracted rate [1]	$15 PCP/$25 specialist (no referral requir
Maternity (physician only)	Member pays 10% of contracted rate [1]	$90 co-payment
MRI/CAT Scan	Member pays 10% of contracted rate [1]	$50 co-payment [2]
Sonograms	Member pays 10% of contracted rate [1]	$25 co-payment
Chemotherapy/Radiation Therapy	Member pays 10% of contracted rate [1]	$15 co-payment
Pre-Admission Testing	Member pays 10% of contracted rate [1]	$0 co-payment
Dialysis	Member pays 10% of contracted rate [1]	$0 co-payment
Cardiac Rehabilitation Therapy	Member pays 10% of contracted rate [1, 7]	$15/$25 co-payment
Physical and Occupational Therapy	Member pays 10% of contracted rate [1, 5]	$15 co-payment
Speech Therapy	Member pays 10% of contracted rate [1, 2, 6]	$15 co-payment [2]
Oral Surgery (refer to plan document)	Member pays 0% of contracted rate	$25 co-payment
Routine Pap Test	Member pays 0% of contracted rate [3]	$0 co-payment [3]
Routine Mammogram	Member pays 0% of contracted rate [3]	$0 co-payment [3]
Routine PSA Screening	Member pays 0% of contracted rate [3]	$0 co-payment [3]
Durable Medical Equipment	Member pays 10% of contracted rate [1]	Member pays 20% of contracted rate up payable at 100% [2]
Home Health Care	Member pays 10% of negotiated rate [1]	$0 co-payment Limited to 150 visits per plan year [2]
Hospice Care	Member pays 20% of negotiated rate [1]	$0 co-payment [2]
Preventive Care (Wellness)	Member pays 0% of contracted rate [3]	$0 co-payment
Annual Eye Exam	Not covered	Not covered
Prescription Drug Benefit In-Network (retail)	Member pays 50%; max $50 per 31-day fill; after $1,200 per person per plan year, co-pay $15 brand, $0 generic **NOTE: Member who chooses brand-name drug for which approved generic version is available pays cost difference between brand-name drug & generic drug, plus 50 percent co-pay for brand-name drug; cost difference does not apply to $1,200 out-of-pocket max.** *(Administered by MedImpact)*	Member pays 50%; max $50 per 31-day f per person per plan year, co-pay$15 bran **NOTE: Member who chooses brand-na which approved generic version is ava difference between brand-name drug plus 50 percent co-pay for brand-nam difference does not apply to $1,200 ou max.** *(Administered by MedImpact)*
Mail Order Prescription Drug Program	Same as above	Same as above
Mental Health/Substance Abuse Treatment - Inpatient	Member pays 10% of contracted rate [1, 2] *(Administered by Blue Cross and Blue Shield of La.)*	$100 co-payment per day; $300 max per *(Administered by Blue Cross and Blue Shiel*
Mental Health/Substance Abuse Treatment - Outpatient	Member pays 10% of contracted rate [1] *(Administered by Blue Cross and Blue Shield of La.)*	$15 office visit co-payment *(Administered by Blue Cross and Blue Shiel*
COVERED BENEFIT: OUT-OF-NETWORK	Member pays 30% of fee schedule [1, 4]	Member pays 30% of fee schedule [4] Separate $1,000 deductible

This comparison chart is a summary of plan features. For full details of the plan, refer to the official plan document.

[1] Subject to plan year deductible and/or co-insurance
[2] Pre-authorization required
[3] Age and/or time restrictions apply
[4] Member pays difference between billed amount and fee schedule
[5] Limited to 50 visits per year
[6] Limited to 26 visits per year
[7] Within 6 months of qualifying event
[8] Member pays any amount above $500 maximum
[9] Not applicable to out-of-network hospital-based providers at in-network facilities. Provider can balance bill patient
[10] Physical therapy maximum of 20 visits per year. Occupational and Speech Therapy combined for maximum 20 visits per plan year
[11] Tier I and Tier II networks available. All medic for the Tier I network. Tier II network benefits re 20% coinsurance.

ctive Employees and Non-Medicare Retirees

	CDHP-HSA (nationwide)** *Administered by Blue Cross and Blue Shield of La.*	**Medical Home HMO Plan (Regions 1,5,6,7,8,9)**[11] *Insured by Vantage Health Plan*
lue Shield of La.	Unlimited	Unlimited
	Must meet deductible before co-insurance applies » Employee - $1,250 » Employee plus one (spouse or child) - $2,500 * » Family - $3,000 *	None
	» Employee - $3,250; including deductible » Employee plus one (spouse or child) - $6,500; including deductible » Family - $9,000 for 3 members; $11,000 for 4 members; $11,900 for 5 or more due to statutory maximum; including deductible	» $1,000 per person » $3,000 per family
per admission	Member pays 20% of contracted rate [1, 2]	$200 per day [2]; $600 maximum per admission
	Member pays 20% of contracted rate [1]	$0 co-pay [9]
mitted	Member pays 20% of contracted rate [1] (prior authorization if admitted)	$150 co-payment; waived if admitted
	Member pays 20% of contracted rate [1]	$200 co-payment [2]
ral required)	Member pays 20% of contracted rate [1]	$5 PCP/$45 specialist (no referral required)
	Member pays 20% of contracted rate [1]	$5 co-pay for initial visit only (no auth required)
	Member pays 20% of contracted rate [1]	$150 co-payment per test [2]
	Member pays 20% of contracted rate [1]	$150 co-payment per test [2] (except maternity)
	Member pays 20% of contracted rate [1]	Member pays 20% [2]
	Member pays 20% of contracted rate [1]	Member pays 0%
	Member pays 20% of contracted rate [1]	20% co-insurance [2]
	Member pays 20% of contracted rate [1, 7]	$45 co-payment per visit [2]
	Member pays 20% of contracted rate, visit limits apply, see plan document [1]	20% co-insurance [2, 10]
	Member pays 20% of contracted rate [1, 6]	20% co-insurance [2, 10]
	Member pays 20% of contracted rate [1]	$45 specialist co-pay or $200 surgery co-pay [2]
	Member pays 0%, deductible does not apply [3]	Member pays 0% [3]
	Member pays 0%, deductible does not apply [3]	Member pays 0% [3]
	Member pays 0%, deductible does not apply [3]	Member pays 0% [3]
d rate up to $5,000, then	Member pays 20% of contracted rate [1, 2]	20% co-insurance [2]
ar [2]	Member pays 20% of contracted rate [1, 2] Limited to 60 visits per plan year	20% co-insurance [2]
	Member pays 20% of contracted rate; 360 day limit [1, 2]	20% co-insurance [2]
	Member pays 0%, deductible does not apply [3]	$0 co-payment
	Not covered	$45 specialist office visit co-payment [3]
r 31-day fill; after $1,200 y$15 brand, $0 generic **brand-name drug for on is available pays cost me drug & generic drug, and-name drug; cost $1,200 out-of-pocket** *act)*	» Level 1 - Generic; 31-day supply; $10 co-pay [1] » Level 2 - Preferred brand; 31-day supply; $25 co-pay [1] » Level 3 - Non-preferred brand; 31-day supply; $50 co-pay [1] » Level 4 - Specialty; 31-day supply; $50 co-pay [1] » Maintenance drugs: 31-day supply; not subject to deductible; subject to applicable co-payment levels 1 through 4 above (*Administered by Express Scripts)*	» Low-cost generic: $3 co-payment per 30-day fill » Non-preferred generics: $10 per 30-day fill » Preferred brand: $45 co-payment per 30-day fill » Non-preferred brand: $95 co-payment per 30-day fill » Specialty drugs: 33% co-insurance per 30-day fill *(Administered by Catamaran)*
	» Level 1 - Generic; 90-day supply; $10 co-payment [1] » Level 2 - Preferred Brand; 90-day supply; $25 co-pay [1] » Level 3 - Non-Preferred Brand; 90-day supply; $50 co-pay [1] » Level 4 - Specialty; 90-day supply; $50 co-pay [1] » Maintenance drugs: 90-day supply; not subject to deductible; subject to applicable co-pay levels [1] through 4 above *(Administered by Express Scripts)*	» 30-day supply for one co-payment » 60-day supply for two co-payments » 90-day supply for three co-payments » Not available for specialty drugs *(Administered by Catamaran)*
max per admit [2] *Blue Shield of La.)*	Member pays 20% of contracted rate [1, 2] (Administered by Blue Cross and Blue Shield of La.)	$200 co-payment per day; $600 maximum admission [2] *(Administered by Vantage Health Plan)*
Blue Shield of La.)	Member pays 20% of contracted rate [1] *(Administered by Blue Cross and Blue Shield of La.)*	$45 co-payment per visit *(Administered by Vantage Health Plan)*
ule [4]	Member pays 30% of fee schedule [1, 4] Wellness - Member pays 0% of fee schedule; deductible does not apply [3, 4]	Worldwide emergency and urgent care covered at Tier 1 in-network benefit level; all other services require prior plan approval; separate deductible of $1000 member/$3000 family and 50% co-insurance applies [1, 2, 4]

le. All medical benefits shown are
k benefits require an additional

Health Savings Account (HSA): *State contributes $200 to each plan member's qualified HSA & matches up to $575 per plan year in additional contributions. Refer to plan document for details.*

** Employee-plus-one unit or family unit must satisfy total deductible before co-insurance applies*
*** Only active employees are eligible to enroll*

OGB Medical Benefits Comparison for Re

Effective January 1, 2014

COVERED BENEFIT: IN-NETWORK	**PPO Plan (nationwide)** *Administered by Blue Cross and Blue Shield of La.*	**HM** *Ad*
Lifetime Maximum Benefit (all eligible expenses)	Unlimited	Un
Plan Year Deductible - Employees and Dependents	$300 retiree Family unit maximum: 3 individual deductions	No No
Maximum Out-Pocket Expense In-Network	$2,000 per person; $12,700 per family	$1
Hospital Services - Inpatient	Member pays 20% of Medicare coinsurance/deductible[1]	Me
Surgeon, Anesthesia, Lab, X-rays & Injections	Member pays 20% of Medicare coinsurance/deductible[1]	Me
Hospital Emergency Room (facility only)	$150 separate deductible; waived if admitted; Member pays 20% of Medicare coinsurance/deductible[1]	$1
Ambulatory Surgical Facilities	Member pays 20% of Medicare coinsurance/deductible[1]	Me
Physician Visits	Member pays 20% of Medicare coinsurance/deductible[1]	Me
MRI/CAT Scan	Member pays 20% of Medicare coinsurance/deductible[1]	Me
Sonograms	Member pays 20% of Medicare coinsurance/deductible[1]	Me
Chemotherapy and Radiation Therapy	Member pays 20% of Medicare coinsurance/deductible[1]	Me
Dialysis	Member pays 20% of Medicare coinsurance/deductible[1]	Me
Cardiac Rehabilitation Therapy	Member pays 20% of Medicare coinsurance/deductible[1, 3]	Me
Physical and Occupational Therapy	Member pays 20% of Medicare coinsurance/deductible[1]	Me
Speech Therapy	Member pays 20% of Medicare coinsurance/deductible[1]	Me
Oral Surgery (refer to plan document)	Member pays 0% of fee schedule	Me
Routine Pap Test	Member pays 0% of contracted rate; age and/or time restrictions apply	Me ag
Routine Mammogram	Member pays 0% of contracted rate; age and/or time restrictions apply	Me ag
Routine PSA Screening	Member pays 0% of contracted rate; age and/or time restrictions apply	Me ag
Durable Medical Equipment	Member pays 20% of Medicare coinsurance/deductible[1]	Me
Home Health Care	Non-covered benefit when Medicare is primary	No
Hospice Care	Non-covered benefit when Medicare is primary	No
Urgent Care	Member pays 20% of Medicare coinsurance/deductible[1]	Me
Ambulance	Member pays 20% of Medicare coinsurance/deductible[1]	Me
Preventive Care (Wellness)	Member pays 0% of contracted rate; age and/or time restrictions apply	Me ag
Prescription Drug Benefit In-Network (retail)	Member pays 50%; max $50 per 31-day fill; after $1,200 per person per plan year, co-payment $15 brand, $0 generic *(Administered by MedImpact)* Plan member is enrolled automatically in OGB's Medicare Part D coverage with a wrap-around	Me pe *(A* Pla co
Mail Order Prescription Drug Program	Same as above	Sa
Mental Health/Substance Abuse Treatment - Inpatient	Member pays 20% of Medicare coinsurance/deductible[1]	Me
Mental Health/Substance Abuse Treatment - Outpatient	Member pays 20% of Medicare coinsurance/deductible[1]	Me
COVERED BENEFIT: OUT-OF-NETWORK		
Hospital Services - inpatient	Same as in-network plus a $50 per day deductible; max $250 per admission	Sa
All other covered services	Same as in-network	Sa

This comparison chart is a summary of plan features. For full details of the plan, refer to the official plan document.

[1] Subject to plan year deductible and/or co-insurance
[2] Pre-authorization required
[3] Complete within 6 months
[4] Waived if using an in-network hospital
[5] Member subject to co-pays/co-insurance if Medicare deductibles have not been met
[6] See plan document for details on drug coverage
[7] These benefits apply when contracted providers are used; if non-contracted providers are used, out of network benefits apply (separate deductible and higher out-of-pocket costs to member).

** Tier I and Tier II networks available. All m for the Tier I network. Tier II network bene 20% coinsurance.*
*** If a Vantage member has Medicare as p coordinates with Medicare as follows:*
• For medical benefits, Vantage pays les responsibility or Vantage allowable

or Retirees with Medicare Part A and Part B

	HMO Plan (nationwide) *Administered by Blue Cross and Blue Shield of La.*	**Medical Home HMO Plan (Offered in regions 1,5,6,7,8,9)***, ** *Insured by Vantage Health Plan*
	Unlimited	Unlimited
	None None	None None
	$1,000 per person; $3,000 per family	$1,000 per person; $3,000 per family
	Member pays 0% of Medicare coinsurance/deductible [5]	Member pays 0% of Medicare coinsurance/deductible [1]
	Member pays 0% of Medicare coinsurance/deductible [5]	Member pays 0% of Medicare coinsurance/deductible [1]
	$100 separate deductible; waived if admitted [5]	Member pays 0% of Medicare coinsurance/deductible [1]
	Member pays 0% of Medicare coinsurance/deductible [5]	Member pays 0% of Medicare coinsurance/deductible [1]
	Member pays 0% of Medicare coinsurance/deductible [5]	Member pays 0% of Medicare coinsurance/deductible [1]
	Member pays 0% of Medicare coinsurance/deductible [5]	Member pays 0% of Medicare coinsurance/deductible [1]
	Member pays 0% of Medicare coinsurance/deductible [5]	Member pays 0% of Medicare coinsurance/deductible [1]
	Member pays 0% of Medicare coinsurance/deductible [5]	Member pays 0% of Medicare coinsurance/deductible [1]
	Member pays 0% of Medicare coinsurance/deductible [5]	Member pays 0% of Medicare coinsurance/deductible [1]
	Member pays 0% of Medicare coinsurance/deductible [5]	Member pays 0% of Medicare coinsurance/deductible [1,2]
	Member pays 0% of Medicare coinsurance/deductible [5]	Member pays 0% of Medicare coinsurance/deductible [1]
	Member pays 0% of Medicare coinsurance/deductible [5]	Member pays 0% of Medicare coinsurance/deductible [1]
	Member pays 0% of Medicare coinsurance/deductible [5]	Member pays 0% of Medicare coinsurance/deductible [1]
	Member pays 0% of contracted rate; age and/or time restrictions apply	Member pays 0% of Medicare coinsurance/deductible [1]
	Member pays 0% of contracted rate; age and/or time restrictions apply	Member pays 0% of Medicare coinsurance/deductible [1]
	Member pays 0% of contracted rate; age and/or time restrictions apply	Member pays 0% of Medicare coinsurance/deductible [1]
	Member pays 0% of Medicare coinsurance/deductible[5]	Member pays 0% of Medicare coinsurance/deductible [1]
	Non-covered benefit when Medicare is primary	Member pays 0% of Medicare coinsurance/deductible [1]
	Non-covered benefit when Medicare is primary	Member pays 0% of Medicare coinsurance/deductible [1]
	Member pays 0% of Medicare coinsurance/deductible[5]	Member pays 0% of Medicare coinsurance/deductible [1]
	Member pays 0% of Medicare coinsurance/deducible [5]	Member pays 0% of Medicare coinsurance/deductible [1]
	Member pays 0% of contracted rate; age and/or time restrictions apply	Member pays 0% of Medicare coinsurance/deductible [1]
son D	Member pays 50%; max $50 per 31-day fill; after $1,200 per person per plan year, co-payment $15 brand, $0 generic *(Administered by MedImpact)* Plan member is enrolled automatically in OGB's Medicare Part D coverage with a wrap-around	» Low-cost generic: $3 co-payment per 30-day fill » Non-preferred generics: $10 per 30-day fill » Preferred brand: $45 co-payment per 30-day fill » Non-preferred brand: $95 co-payment per 30-day fill » Specialty drugs: 33% co-insurance per 30-day fill *(Administered by Catamaran)*
	Same as above	» 30-day supply for one co-payment » 60-day supply for two co-payments » 90-day supply for three co-payments (Not available for specialty drugs) *(Administered by Catamaran)*
	Member pays 0% of Medicare coinsurance/deductible [5]	Member pays 0% of Medicare coinsurance/deductible
	Member pays 0% of Medicare coinsurance/deductible [5]	Member pays 0% of Medicare coinsurance/deductible [2]
er	Same as in-network	Prior approval required; if approved plan pays up to Medicare allowable***
	Same as in-network	Prior approval required; if approved plan pays up to Medicare allowable***

ilable. All medical benefits shown are
twork benefits require an additional

ledicare as primary coverage, Vantage
follows:
age pays lesser of Medicare patient
allowable

- *Certain Vantage member cost-share amoutns (co-pays and Tier 1 co-insurance) are waived*
- *All pre-authorization requirements for in-network medical benefits are waived for members with Medicare primary*

**** All co-pays are waived; separate deductible of $1,000 member/$3,000 family and 50% co-insurance apply*

Effective January 1, 2014

OGB Medical Benefits Compariso

COVERED BENEFIT: IN-NETWORK	**Peoples Health HMO-POS**	**Vantage HMO-POS**
Lifetime Maximum Benefit	Unlimited	Unlimited
Plan Year Deductible	$0	$0
Maximum Out-of-Pocket Expense	$2,500	$5,900
Inpatient Hospital Services [1, 4]	$0 co-pay	$275 co-pay per day (days 1
Outpatient Hospital Care	$0 co-pay	$275 co-pay
Surgery, Anesthesia & X-ray	$0 co-pay	$0 co-pay for physician
Hospital Emergency Room (Worldwide - facility only)	$50 co-pay; waived if admitted	$65 co-pay; waived if admit
Ambulatory Surgical Facilities	$0 co-pay	$275 co-pay
Physician Visits - Primary Care/Specialty Care	$5/$10 co-pay	$5/$40 co-pay
MRI/CAT Scan	$0 co-pay	Up to $150 co-pay
Sonograms	$0 co-pay	Up to $150 co-pay
Chemotherapy & Radiation Therapy	Chemo - 5% co-insurance Radiation - $0 co-pay	20% co-insurance
Dialysis	$0 co-pay	20% co-insurance
Cardiac Rehabilitation Therapy	$0 co-pay	20% co-insurance
Physical and Occupational Therapy	$0 co-pay	$40 co-pay
Speech Therapy	$0 co-pay	$40 co-pay; subject to Med
Routine Preventive Care (Wellness Program)		
Routine Exams	$0 co-pay	$0 co-pay
Well Woman Care	$0 co-pay	$0 co-pay
Immunizations	$0 co-pay	$0 co-pay
PSA Test	$0 co-pay	$0 co-pay
Oral Surgery	Medicare coverage guidelines apply; check health plan for details	Medicare coverage guidelin check health plan for detail
Durable Medical Equipment	5% co-insurance	20% co-insurance
Home Health Care	$0 co-pay	$0 co-pay
Hospice Care [3]	$0 co-pay	$0 co-pay
Prescription Drug Benefits - Retail		
Level 1 - Preferred Generic	$0 co-pay	$3 co-pay
Level 2 - Generic	$0 co-pay	$10 co-pay
Level 3 - Preferred Brand	$20 co-pay	$45 co-pay
Level 4 - Non-Preferred Brand	$40 co-pay	$95 co-pay
Level 5 - Specialty	20% co-insurance	33% co-insurance
Mail Order Drug Program - 90-day supply		
Level 1 - Preferred Generic	$0 co-pay	$9 co-pay
Level 2 - Generic	$0 co-pay	$30 co-pay
Level 3 - Preferred Brand	$40 co-pay	$135 co-pay
Level 4 - Non-Preferred Brand	$80 co-pay	$285 co-pay[2]
Level 5 - Specialty	20% co-insurance	Not available
Mental Health [4]		
Inpatient	$0 co-pay	$370 co-pay per day (days 1
Outpatient (per visit)	$0 co-pay	$40 co-pay
Partial Hospitalization	$0 co-pay	$55 co-pay
Alcohol and Substance Abuse Treatment [4]		
Inpatient	$0 co-pay	$275 co-pay per day (days 1
Outpatient (per visit)	$0 co-pay	$40 co-pay
Pre-Admission Testing	$0 co-pay	$0 co-pay
Skilled Nursing Care	$0 co-pay (days 1-20) $25 co-pay (days 21-100)	$25 co-pay (days 1-20) $152 co-pay (days 21-100)
Urgent Care	$10 co-pay	$65 co-pay
Ambulance	$50 co-pay	$250 co-pay per trip

This comparison chart is a summary of plan features. For full details of the plan, refer to the official plan document.

[1] Semi-private room, ancillary services & physician visits
[2] No coverage through the Gap (donut hole)
[3] Covered by Medicare
[4] Some services may require pre-certification
[5] Health Maintenance Organization - Point-of-Service Option

rison for Medicare Advantage Plans

POS	Vantage Zero-Premium HMO-POS
	Unlimited
	$0
	$6,700
ay (days 1-5)	$335 co-pay per day (days 1-5)
	$450 co-pay
ician	$0 co-pay for physician
d if admitted	$65 co-pay; waived if admitted
	$450 co-pay
	$9/$50 co-pay
	Up to $175 co-pay
	Up to $175 co-pay
	20% co-insurance
	20% co-insurance
	20% co-insurance
	$40 co-pay
t to Medicare maximum	$40 co-pay; subject to Medicare maximum
	$0 co-pay $0 co-pay $0 co-pay
	$0 co-pay
e guidelines apply; for details	Medicare coverage guidelines apply; check health plan for details
	20% co-insurance
	$0 co-pay
	$0 co-pay
	$3 co-pay $10 co-pay $45 co-pay $95 co-pay after $300 Medicare deductible [2] 25% co-insurance after $300 Medicare deductible [2]
	$9 co-pay $30 co-pay $135 co-pay $285 co-pay after $300 Medicare deductible [2] Not available
ay (days 1-4)	$370 co-pay per day (days 1-4) $40 co-pay $55 co-pay
ay (days 1-5)	$335 co-pay per day (days 1-5) $40 co-pay
	$0 co-pay
-20) 21-100)	$25 co-pay (days 1-20) $152 co-pay (days 21-100)
	$65 co-pay
ip	$250 co-pay per trip

How Do I Choose?

The answers to these questions can help you decide which OGB health plan is right for you...

- ✓ Is the plan available in my area?
- ✓ Are my hospitals and doctors included in the plan?
- ✓ Does the plan have an open or closed (restricted) drug formulary?
- ✓ Does the plan have drug coverage in the coverage gap or "donut hole"?
- ✓ If the formulary is closed (restricted), are my prescription drugs covered?
- ✓ What is the monthly premium cost?
- ✓ How do the plan's costs and benefits compare to my current plan?
- ✓ If I need out-of-state coverage, does the plan have it?

Individual Medicare Plans through Extend Health Exchange

OGB is partnering with Extend Health, the largest private Medicare exchange in the United States, to offer access to multiple individual Medicare plans for 2014. Retirees who enroll in an individual Medicare plan through the Extend Health exchange will be enrolled in a health reimbursement arrangement (HRA) and will receive HRA credits of $200 to $300 per month from the state – up to $2,400 per year with single coverage or up to $3,600 per year with coverage for more than one Medicare beneficiary. They can use these HRA credits to pay premiums for Medicare Advantage plans, Medicare Part B, Medicare Part D prescription drug plans, Medigap plans, dental plans, vision plans and other eligible out-of-pocket medical expenses. Extend Health's HRA administrator may be reached by calling toll-free 866-245-8953. Retirees who want enrollment information may call Extend Health at 855-663-4228.

OGB Medicare Advantage Enrollment and OGB Annual Enrollment *What's the difference?*

OGB Annual Enrollment is the time period each year when all OGB plan members can transfer to an OGB standard health plan (the PPO, HMO, Medical Home HMO and CDHP-HSA health plans). The CDHP-HSA health plan is for eligible active plan members only. For the 2014 plan year, Annual Enrollment begins October 1 and ends October 31.

OGB Medicare Advantage Enrollment is when retirees with both Medicare Part A and Part B can transfer to an OGB Medicare Advantage health plan. For the 2014 plan year, Medicare Advantage Enrollment begins October 15 and ends December 7, 2013.

Both enrollments take place once a year in the fall with an effective date of coverage on January 1. Although the two enrollment periods overlap, the beginning and ending dates vary.

October 1 - October 31, 2013 All plan members can transfer to an OGB standard plan. Retirees with Medicare Part A and Part B can transfer to an OGB Medicare Advantage plan.	**October 15 - December 7, 2013** Retired plan members with Medicare Part A and Part B can transfer to an OGB Medicare Advantage plan or transfer back to an OGB standard plan.	**January 1, 2014** Effective date for OGB standard health plans and Medicare Advantage plans.

Continuation of Coverage

Unless Continuation of Coverage is available and selected as provided in this Benefit Plan, an Employee's coverage terminates as provided below:

1. The Employee's coverage and that of all his Dependents automatically, and without notice, terminates at the date of the termination date.
2. The coverage of the Employee's spouse will terminate automatically, and without notice the date of a final decree of divorce or other legal termination of marriage.
3. The coverage of a Dependent will terminate automatically, and without notice, the date the Dependent ceases to be an eligible Dependent.
4. Upon the death of an Employee, the coverage of all of his surviving Dependents will terminate automatically and without notice at the end of the billing cycle in which the death occurred if premiums have been paid through that period the date that death occurred. However, a surviving spouse or Dependent may elect continuation of coverage as described elsewhere in this Benefit Plan.

Notice of Right to Continue Group Health Coverage

If You Have Coverage Outside of OGB

Special Enrollment under HIPAA

Under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), if you decline enrollment for yourself or your dependents (including your spouse) because of other coverage, you may in the future be able to enroll yourself and your dependents in this plan under Special Enrollment, provided that you request enrollment **within 30 days after your other coverage ends**.

- To qualify for this Special Enrollment, HIPAA requires the completion of a waiver of coverage at the time of initial eligibility.
- If you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents under Special Enrollment, provided that you request enrollment within 30 days of acquiring the new dependent.
- The effective date of coverage for Special Enrollment is the first of the month following the date OGB receives all required enrollment forms.
- The participation schedule applies to Special Enrollment provisions.

COBRA

COBRA gives you and your covered dependents the right to choose to continue group health coverage for limited periods of time when coverage is lost under circumstances such as voluntary or involuntary job loss, reduction in hours worked, transition between jobs, death, divorce, and other life events. Individuals who choose COBRA continuation coverage are required to pay the entire premium for coverage in most situations.

Retiree 100 Program

What is Retiree 100?

Retiree 100 is optional coverage available to retired plan members in an OGB Sponsored PPO plan who have Medicare Part A and Part B as their primary insurer.

Normally, Medicare and your OGB sponsored plan reimburse a significant percentage of your eligible health care expenses. However, since Medicare reimburses only part of the cost, and OGB pays benefits only on what is left after Medicare pays, you usually have to pay part of the costs as well.

Retiree 100 coverage may provide higher reimbursements for eligible medical expenses (after deductibles are met) by considering the total charges billed by an eligible provider, not just the balance due after Medicare has paid.

Advantage of the Retiree 100 Program

The advantage of the Retiree 100 program is additional coverage for members who have extensive hospital bills and/or large amounts of physician charges due to a serious illness, accident or long-term chronic condition.

Who is Eligible to Enroll?

You are eligible to enroll in Retiree 100 if:

» You are a retired state employee
» You are a member of OGB's PPO plan
» Medicare is your primary insurer
» You have both Medicare Part A and Part B

You can also enroll your spouse if:

» You currently cover your spouse as a dependent
» Medicare is your spouse's primary health insurer
» Your spouse has both Medicare Part A and Part B

Not All Expenses Are Eligible

Retiree 100 coordinates only those expenses considered eligible for reimbursement by both Medicare and your OGB sponsored PPO plan.

Expenses not eligible for consideration include:

» **Benefits assigned** - when a provider agrees to accept what Medicare allows as full payment. (OGB does not pay for any portion of a bill in excess of the Medicare allowable amount.)
» **Prescription drugs**

Retiree 100 Program

Premiums

The monthly premium for Retiree 100 is $39.00 per person **in addition** to your monthly OGB premium. **There is no state contribution** toward the premium amount; you must pay the entire cost for Retiree 100 coverage.

Enrollment

If you are already retired, you can enroll during the Annual Enrollment period held each year. Also, you can enroll within 30 days after the date you first became eligible for Medicare (Parts A and B). Coverage becomes effective on the first day of the month you became eligible for Medicare.

If you are an active employee who is eligible for Medicare, you can enroll during the Annual Enrollment period held each year. Also, you have 30 days from the date you retire to enroll. Coverage becomes effective on the first day of the first full month of retirement.

- You are eligible for benefits the very first day you are covered.
- Enrollment documents are available through your human resources department, OGB's Baton Rouge walk-in office and on the OGB website, www.groupbenefits.org.

Option to Cancel at Any Time

You can cancel Retiree 100 coverage at any time by notifying the OGB Eligibility Division in writing. Your letter should include the plan member's name, address, telephone number and Social Security number. Cancellation becomes effective on the last day of the month in which your notice of cancellation is received by OGB.

If you drop Retiree 100 coverage, you can enroll again during any Annual Enrollment period, as long as you continue to meet the eligibility requirements.

Notice to OGB Retirees Who Reached Age 65 on or after July 1, 2005

If you are eligible for Medicare Part A premium-free (hospitalization insurance), you MUST also enroll in Medicare Part B (medical insurance) to receive OGB benefits on Medicare Part B claims.

- This does not apply to you if you reached age 65 before July 1, 2005.
- If you are retired, but not yet age 65, this will apply to you when you reach age 65.
- If you reached age 65 on or after July 1, 2005, but have not retired, this will apply to you when you retire.
- This applies to you and your covered spouse regardless of whether each of you has individual Medicare eligibility (under your own Social Security number) or one of you is eligible as a dependent of the other.
- You should visit the nearest Social Security Administration office about 90 days before you or your spouse reach age 65 to determine if you are eligible for Medicare coverage.

If you are **not** eligible for Medicare Part A premium-free, obtain a letter or other written verification from the Social Security Administration confirming you are not eligible for Medicare. Send a copy to OGB at P.O. Box 66678, Baton Rouge, LA, 70896.

Services Requiring Pre-Certification

Pre-Admission Certification and Continued Stay Review

Pre-Admission Certification (PAC) and Continued Stay Review (CSR) establish the medical necessity and length of inpatient hospital confinement.

It is the in-network provider's responsibility to obtain PAC for in-network facilities. If the in-network provider fails to do this, the plan member cannot be billed for any amount not covered by this plan.

It is the plan member's responsibility to assure that PAC is obtained at non-network facilities.

For childbirth, PAC is not required for routine vaginal deliveries when the stay is two days or less or for Cesarean sections when the stay is four days or less. If the mother's stay exceeds or is expected to exceed two days, PAC is required within 24 hours after the delivery or on the date on which any complications arose, whichever is applicable. If the baby's stay exceeds that of the mother, PAC is required within 72 hours of the mother's discharge and a separate pre-certification number must be obtained for the baby.

To meet pre-admission certification requirements and receive benefits:

» Pre-admission certification must be requested prior to admission.
» Pre-admission certification must be requested within 2 working days following an emergency admission.

No benefits will be paid:

» For hospital charges incurred during any confinement for which PAC was requested, but was not certified as medically necessary by the program's utilization review contractor.
» For hospital charges incurred during any confinement for any days in excess of the number of days certified through PAC or CSR.

Outpatient Therapies Requiring Pre-Certification

In-network providers are required to pre-certify these therapies and the related diagnoses. If the provider fails to do this, the plan member cannot be billed for any amount not covered by OGB.

It is the plan member's responsibility to assure that outpatient pre-certification is requested on services performed by non-network providers. No benefits will be paid if outpatient pre-certification is not obtained. To obtain pre-certification, call the number on your medical identification card.

Therapies that require pre-certification prior to service include:

» Speech therapy
» Physical therapy and occupational therapy – ONLY when performed in home setting after 50 visits
» Hyperbaric oxygen therapy (HBOT)

Remember:

Pre-admission certification must be requested prior to admission.

Pre-admission certification must be requested within 2 working days following an emergency admission.

Prescription Drug Program

The prescription drug benefits listed on pages 17-18 are for active employees and non-Medicare retirees who are enrolled in the PPO and HMO health plans ONLY. For information about prescription drug benefits for retirees with Medicare Part A and Part B who are enrolled in the PPO or HMO health plan, see page 9.

OGB contracts with a prescription benefits manager (PBM) with a network of conveniently-located pharmacies and an optional mail service program.

The prescription drug benefit for OGB's PPO and HMO health plans pays only the cost of the generic version of any prescription drug for which a generic approved by the U. S. Food and Drug Administration (FDA) is available.

If you choose to buy a brand-name prescription for which an FDA-approved generic is available, you pay the difference in cost between the brand-name drug and the FDA-approved generic version, plus the 50 percent co-insurance amount for the brand-name medication up to a maximum of $50 per 31-day fill. That cost difference does not apply to the $1,200 maximum out-of-pocket cost for the plan year.

After the $1,200 out-of-pocket maximum (per person per plan year) is met, the co-insurance maximum decreases to $15 for brand-name drugs for which no FDA-approved generic version is available and $0 for generics. However, you still pay the cost difference between the brand drug and the approved generic if you choose a brand drug when an approved generic is available.

If it is medically necessary for you to take a brand-name drug instead of the generic version, the doctor who prescribed the drug must request authorization for an exception from MedImpact by submitting a written explanation providing documented reasons why it is medically necessary for you to take the brand-name drug instead of the generic. It is important to submit the request well in advance of the next refill date to allow sufficient time for MedImpact to respond. MedImpact will review each request on a case-by-case basis and notify your doctor of the decision in writing.

Examples of Your Cost for Generic and Brand-Name Prescription Drugs

Example #1 - Brand-name drug
(FDA-approved generic drug available)

Brand-name drug cost	$250.12
Generic drug cost	$41.41
Cost difference	$208.71
50% co-insurance to a maximum of $50	$41.41
Plan member cost	$250.12
OGB health plan cost	$0

Example #2 - Brand-name drug
(FDA-approved generic drug available)

Brand-name drug cost	$48.68
Generic drug cost	$40.23
Cost difference	$8.45
50% co-insurance to a maximum of $50	$24.34
Plan member cost	**$32.79**

Example #3 - Brand-name drug
(No FDA-approved generic drug available)

Brand-name drug cost	$89.74
Generic drug cost	NA
Cost difference	NA
50% co-insurance to a maximum of $50	$44.87
Plan member cost	$44.87
OGB health plan cost	$44.87

Prescription Drug Program

Non-Network Pharmacy
You must pay full drug costs at the point of purchase and submit your receipt. You will be reimbursed based on the discounted drug costs at network pharmacies, less your co-pay.

For additional information about your pharmacy benefits, refer to your plan document or call the telephone number on your identification card.

Extended Drug Benefit
For refills obtained within 120 days of the previous fill, you can obtain up to a 93-day supply of medications if prescribed by your doctor and if 75 percent of the amount previously dispensed has been used. Remember, prescriptions are limited to the dispensing amount prescribed.

The out-of-pocket maximum is $1,200 per person, per plan year. ***This out-of-pocket maximum applies only to generic drugs and brand-name drugs when no generic equivalent drug is available.*** There is no separate lifetime maximum for prescription drugs. The unlimited medical lifetime maximum includes charges incurred for prescription drugs.

Supply	Your Cost
1- to 31-days	One month's co-pay
32- to 62-day supply	Two months' co-pay
63- to 93-day supply	Three months' co-pay

After the out-of-pocket limit of $1,200 has been met, you pay the following:

Brand-name drugs - when generic is not available	
Supply	**Your Cost**
1- to 31-days	$15
32- to 62-day supply	$30
63- to 93-day supply	$45
Generic drugs	
31-day, 62-day or 93-day supply	$0

For assistance in finding a network pharmacy near you, call the toll-free number on the back of your ID card.

Benefit for Proton Pump Inhibitors (PPI)
The prescription drug benefit for the OGB PPO, OGB HMO and CDHP health plans now covers over-the-counter (OTC) proton pump inhibitor (PPI) medications for heartburn and gastroesophageal reflux disease (GERD) – if the plan member has a prescription from his or her physician. These OTC PPI medications are equally effective for most people and far less costly. This saves money for both the plan member and the health plan, which helps OGB keep premium rates as low as possible. The plan member pays 50 percent of the cost of these OTC PPI medications at the point of purchase (up to a $50 maximum per prescription for up to a 31-day supply):

- lansoprazole (sold as Prevacid 24 Hour; store brands are not yet available)
- omeprazole (sold as Prilosec OTC and various store brands
- omeprazole and sodium bicarbonate (sold as Zegerid OTC; store brands are not yet available)

The plan member must pay a co-pay for each full or partial 31-day supply, so OGB urges plan members to make sure providers keep package sizes in mind when writing OTC PPI prescriptions.

Prescription Drug Program

How to Use the Retail Pharmacy Program

At Participating Pharmacies
Present your ID card at the network pharmacy each time you purchase a prescription drug. The pharmacist will use a computerized system to confirm your eligibility for benefits and determine the amount of your co-payment.

At Non-Participating Pharmacies
Pay the full amount of the prescription at the time of purchase and obtain a prescription drug receipt. You may pay more when you use a non-participating pharmacy, because fees have been negotiated with network pharmacies.

To obtain reimbursement, you must submit a claim form. Fill out a prescription drug claim form, attach the receipt(s) and mail to the address shown on the claim form. To obtain forms, call the pharmacy benefits number on the back of your ID card.

Mail service is also available.

Mental Health and Substance Abuse Treatment Benefits

Accessing Your Benefits

Mental health and substance abuse (MH/SA) treatment benefits are administered by a behavioral health company contracted by OGB. You and your covered family members can get care by calling the number on your identification card.

When you call, a customer service representative or care manager will help you select a network provider who is located convenient to your home or workplace. If you need immediate assistance, clinical staff is available 24 hours a day to assist you with finding a provider and obtaining authorization for services. Your mental health and substance abuse treatment benefits include a range of services. When authorized, these services may include:

» Inpatient care
» Intensive outpatient programs
» Partial day treatment
» Detoxification and substance abuse treatment
» Psychiatry evaluation and office visits (prior authorization is not required for out-of-office visits)
» Outpatient treatment by psychologists, licensed professional counselors and licensed clinical social workers (prior authorization is not required for outpatient office visits)

Pre-Authorization Requirements

» Required for inpatient treatment.
» All services must meet medical necessity criteria to be eligible for reimbursement.
» The member must see a network provider to be eligible for in-network benefits.
» Call the number on your identification card for assistance in selecting a network provider.

OGB processes medical claims filed by physicians for patients who have ADD or ADHD. Such claims were previously processed for payment only to mental health providers.

Mental Health and Substance Abuse Treatment Benefits

Deductibles

Plan members are not responsible for a separate deductible for MH/SA treatment services. MH/SA treatment services are included in the Comprehensive Medical Benefits deductible and applies to all inpatient and outpatient services, including those for ADD and ADHD.

You must receive care from an in-network provider or facility to receive in-network benefits. Assistance is available 24 hours a day to help you find a provider and obtain authorization for services.

In Case of a Mental Health and/or Substance Abuse Emergency

Clinicians are available 24 hours a day to help you in a serious situation. If the situation is life-threatening and you believe inpatient services are needed, call 911, or go to the nearest emergency room.

Emergency services are reimbursed if, after review, presentation is determined to be life-threatening, resulting in admission to inpatient, partial hospital or intensive outpatient level of care.

Your doctor or a family member *must* **call the number on your identification card within 24 hours to receive authorization for services.**

After emergency stabilization, the care manager will assist if needed in arranging for a transfer to an in-network facility. Non-emergency MH/SA problems treated in the emergency room will not be eligible for reimbursement.

Your Right to Appeal

If you or your provider disagrees with a clinical determination, you have the right to appeal. Appeal requests can be made by calling the MH/SA number on your identification card.

Important Guidelines

You MUST call to obtain pre-authorization BEFORE you receive inpatient mental health and substance abuse treatment. If you do not receive pre-authorization, you will not be eligible to use your OGB MH/SA treatment benefits.

You MUST receive care from an in-network provider or facility to receive in-network benefits.

By following these guidelines, you will help OGB ensure that you get care quickly and from a provider whose credentials and experience have been thoroughly reviewed and approved.

Flexible Benefits Plan

Give *yourself* a pay raise this year! You can save money and reduce your taxes by enrolling in one or more of these benefits. If applicable, this might produce lower Social Security benefits.

» **Premium Conversion** – allows you to pay the employee share of your eligible health coverage and insurance premiums before taxes are calculated.

» **General-Purpose Health Care Flexible Spending Arrangement (GPFSA)** – allows you to use pre-tax dollars to pay eligible out-of-pocket medical, dental and vision care expenses for you, your spouse and/or your federal tax dependents – even if they are not covered by your health plan. Employees cannot participate in a GPFSA and a Health Savings Account (HSA) at the same time. There is a one-year employment requirement for participation. This is a HIPAA-excepted benefits plan.

» **Limited-Purpose Dental/Vision Flexible Spending Arrangement (LPFSA)** – limited to eligible out-of-pocket **dental and vision expenses only**. This is a HIPAA-excepted benefits plan.

- The one-year employment eligibility rule is the same as for the General-Purpose FSA (GPFSA).
- The LPFSA is available for all full-time employees, including employees who have enrolled in the Consumer-Driven health plan with a Health Savings Account (CDHP-HSA) option.
- Employees cannot participate in both the GPFSA and the LPFSA at the same time.

» **Dependent Care Flexible Spending Arrangement (DCFSA)** – allows you to use pre-tax dollars to pay eligible dependent care expenses for your child, disabled spouse, elderly parent or other dependent incapable of self-care.

» **Health Savings Account (HSA)** – allows you and your employer, if applicable, to contribute pre-tax dollars to an OGB Health Savings Account. **Employees can only contribute to the HSA** when they also choose the qualifying Consumer-Driven health plan (CDHP-HSA) offered by OGB and are not covered by any disqualifying non-high-deductible health plan.

Employees can participate in the General-Purpose Health Care FSA, the Limited-Purpose Dental/Vision FSA or the Dependent Care FSA benefit even if they are not enrolled in an OGB health plan or the Premium Conversion benefit!

Who is eligible?

Active, full-time employees (as defined by employer) are eligible if they are part of a participating payroll system, listed below.

Flexible Benefits Plan

Administration	
HCM (ISIS/HR) System	
Boards and Commissions	
Louisiana Board of Examiners of Nursing Facility Administrators	Louisiana State Board of Certified Public Accountants
Louisiana Board of Massage Therapy	Louisiana State Board of Cosmetology
Louisiana Board of Nursing	Louisiana State Board of Medical Examiners
Louisiana Board of Physical Therapy Examiners	Louisiana State Board of Social Work Examiners
Louisiana Cemetery Board	Louisiana State Board of Wholesale Drug Distributors
Louisiana Motor Vehicle Commission	Louisiana State Licensing Board of Contractors
Louisiana Patient's Compensation Fund	Louisiana Used Motor Vehicle Commission
Louisiana Pilotage Fee Commission	New Orleans City Park
Louisiana Private Security Examiners	New Orleans Redevelopment Authority
Charter Schools and School Boards	
Cameron Parish School Board	Glencoe Charter School
D'Arbonne Woods Charter School	J. S. Clark Leadership Academy
Delhi Charter School	Louisiana Key Academy
Delta Charter School	Maxine Gardina Charter School
East Carroll Parish School Board	Special Education District 1
Colleges and Universities	
Baton Rouge Community College	McNeese State University
Bossier Parish Community College	Nicholls State University
Delgado Community College	Southeastern Louisiana University
Grambling State University	University of Louisiana at Monroe
Louisiana Community and Technical College System	University of New Orleans
Louisiana Tech University	
Housing Authorities	
East Baton Rouge Parish Housing Authority	Ruston Housing Authority
Louisiana Housing Finance Agency	
Judicial Branch	
Criminal District Court of New Orleans	Jefferson Parish Judges
Eighteenth Judicial District Court	Office of the Judicial Administrator
Fifth Circuit Court of Appeal	Second Circuit Court of Appeal
Florida Parishes Juvenile Justice Commission	Supreme Court of Louisiana
Fourth Circuit Court of Appeal	Twenty-Fourth Judicial District Court
Legislative Branch	
Legislative Budgetary Control Council	Louisiana State Senate
Legislative Fiscal Office	Office of the Legislative Auditor
Levee Districts and Ports	
Atchafalaya Basin Levee District	Orleans Levee District
Caddo Levee District	Sabine River Authority
Greater Lafourche Port Commission	St. Bernard Port, Harbor and Terminal District
Natchitoches Levee and Drainage District	The Port of Morgan City
Non-Flood Protection Asset Management Authority	The Port of South Louisiana
Retirement Systems	
Louisiana School Employees Retirement System	Municipal Police Employees Retirement System
Louisiana State Employees' Retirement System	Teachers' Retirement System of Louisiana
Louisiana State Police Retirement System	

Flexible Benefits Plan

New hires who were not previously employed by a public agency are eligible to enroll in the Premium Conversion option and the Dependent Care flexible Spending Arrangement (DCFSA) **within 30 days of their hire date.**

Enrollment in the General-Purpose Health Care FSA (GPFSA) and the Limited-Purpose Dental/Vision FSA (LPFSA) is limited to active, full-time employees who have **a minimum of 12 consecutive months of continuous employment at a participating agency from January 1, 2013, through December 31, 2013**, and who enroll during Annual Enrollment. New hires from a public agency who were participating in a GPFSA or a LPFSA with their prior public employer are eligible to enroll in the GPFSA or LPFSA within 30 days of their hire date for the reminder of the Flexible Benefits plan year, which runs from January 1, 2014, through December 31, 2014.

Enrollment in the Health Savings Account (HSA) option is limited to a Health Savings Account-eligible individual who has enrolled in the OGB Consumer-Driven health plan with a Health Savings Account (CDHP-HSA) option and is not covered by any disqualifying non-high-deductible health plan. Participating employees must complete a Health Savings Account Enrollment Form during Annual Enrollment and enroll each year.

Rehired retirees who are employed as active, full-time employees are eligible for all options.

Premium Conversion Benefit - Enrollment Information
Eligible employees who want their eligible health coverage and insurance premiums deducted before calculation of taxes must complete a State of Louisiana Flexible Benefits Premium Conversion Enrollment/ Stop Form. This form is available at your human resources/payroll department or you can download the form from OGB's website. The completed form must be returned to your human resources/payroll department.

Insurance Products Eligible for Premium Conversion
The following is a list of insurance companies and their eligible insurance products that are offered through the HCM (ISIS/HR) payroll system. Other payroll systems may have some of these products. Check with your human resources/payroll department to see which products are offered through your payroll system.

Products Eligible for Premium Conversion	
Office of Group Benefits	All OGB Standard Health Plans/Health Savings Account Basic and Basic Plus Supplemental/Term Life (Prudential) – employee only
American Family Life Assurance (AFLAC)	Cancer/Hospital Indemnity/Intensive Care
American Heritage Life Insurance Co.	Cancer
American Public Life Insurance Co.	Dental
Colonial Life and Accident Insurance Co.	Cancer/Hospital Indemnity/Intensive Care
Guaranty Assurance Co.	Dental (DINA)
Guaranty Income Life	Dental (Q-Dent)
MS of A Dent-All Plan, Inc.	DentalVision/Rx/Hearing/Cosmetic Surgery/Teeth Whitening/ Weight Loss/Massage Therapy/Health Care Supplements
National Teachers Associates Life	Cancer/Heart
Starmount Life Insurance Co.	Dental/Vision
Trans America Life Insurance Co.	Cancer/Heart

Flexible Benefits Plan

Below are additional eligible insurance products that are not offered through the ISIS/HR payroll system but are offered through some other payroll systems.

Products Eligible for Premium Conversion (Not HCM)	
Allstate Corporation	Cancer
American Family Life Assurance (AFLAC)	Dental/Vision
American Public Life Insurance Co.	Cancer
Ameritas Group	Dental
Brokers National Life	Dental
Crescent (Meritain Health)	Dental/Vision
Davis	Vision
Delta	Dental
Metlife	Dental
Spectera	Vision
United Healthcare	Vision
VSP (Vision Service Plan Insurance Co.)	Vision

The IRS does not allow insurance products with cash value or a return of premium riders to be included in the Premium Conversion benefit.

There is no administrative fee for participating in the Premium Conversion benefit. Once you enroll in this benefit, you will automatically continue participating in it from one year to the next year. Your eligible insurance payroll deductions are for the Flexible Benefits Plan Year (January 1, 2014, through December 31, 2014). Changes to your deductions can only be made when you experience a qualifying event as defined by the IRS.

Flexible Benefits Plan - General-Purpose Health Care FSA

Do you pay out-of-pocket medical expenses? Do you or your children have dental needs in the upcoming year? If you do, then the General-Purpose Health Care Flexible Spending Arrangement (GPFSA) could save you money.

Important information to remember:

» Your enrollment is for the Flexible Benefits plan year (Jan. 1 through Dec. 31, 2014) and changes can only be made when you experience a qualifying event as defined by the IRS.

» Enrollment in the General-Purpose Health Care FSA (GPFSA) is limited to active, full-time employees who have a minimum of 12 consecutive months of continuous employment at a participating agency from January 1, 2013, through December 31, 2013, and who enroll during Annual Enrollment. New hires from a public agency who were participating in a GPFSA or a LPFSA with their prior public employer are eligible to enroll in the GPFSA or LPFSA within 30 days of their hire date for the remainder of the Flexible Benefits plan year, which runs from Jan. 1 through Dec. 31, 2014.

» The minimum deposit is $600. The maximum deposit is $2,500, plus any IRS-approved cost-of-living adjustment.

» Any balance in the account after the end of the plan year, the Grace Period and the Run-Out Period will be forfeited and will not be returned to you, in accordance with the IRS "use or lose" rule.

- The Grace Period modifies the IRS "use or lose" rule. **Participants have until March 15 to incur eligible expenses to be reimbursed from unused amounts remaining at the end of the immediately preceding plan year, which ends December 31.**
- The Run-Out Period is the 45-day time period after the end of the Grace Period, during which participants can submit eligible expenses incurred during the preceding plan year and the Grace Period for reimbursement. **Eligible expenses must be received by April 29 to be paid from funds remaining at the end of the immediately preceding plan year.**

» Employees who participate in the GPFSA are required to pay the annual administrative fee.

» You must **re-enroll** every year during the Flexible Benefits Annual Enrollment period to continue participation.

» You can have immediate access to your Flexible Spending Arrangement dollars with the FSA card and use the FSA card for purchases of non-medicine items such as bandages, reading glasses and diabetes monitoring supplies. You must obtain a receipt and fax a copy of the receipt to the Flexible Benefits plan

administrator within two weeks upon request.

» However, instead of using your FSA card for over-the-counter purchases such as allergy and cold medicines, ointments and pain relievers, you must submit a doctor's prescription, a claim form and an itemized receipt for each prescribed item purchased. You can submit the same prescription throughout the plan year and can be reimbursed by check or by direct deposit.

An eligible employee who wants to set aside money for out-of-pocket expenses out of his or her paycheck before taxes are calculated must complete a State of Louisiana Flexible Spending Arrangement Enrollment Form. This form is available from your human resources/payroll department or you can download the form from OGB's website. The completed form must be returned to your human resources/payroll department.

During Annual Enrollment only, agencies are not required to fax the Flexible Spending Arrangement Enrollment Form.

Flexible Benefits Plan — Limited-Purpose Dental/Vision FSA

Are you enrolled in the OGB Consumer-Driven health plan and the health savings account option? If so, then the Limited-Purpose Health Care FSA could save you money.

Important information to remember:

» Your enrollment is for the Flexible Benefits Plan Year (Jan. 1 through Dec. 31, 2014) and changes can only be made when you experience a qualifying event as defined by the IRS.

» Enrollment in the Limited-Purpose Dental/Vision FSA (LPFSA) is limited to active, full-time employees who have **a minimum of 12 consecutive months of continuous employment at a participating agency from January 1, 2013, through December 31, 2013, and who enroll during Annual Enrollment. New hires from a public agency who were participating in a GPFSA or a LPFSA with their prior public employer are eligible to enroll in the GPFSA or LPFSA within 30 days of their hire date for the remainder of the Flexible Benefits plan year, which runs from Jan. 1, 2014, through Dec.31, 2014.**

» Employees who participate in the LPFSA are required to pay the administrative fee.

» The minimum deposit is $600. The maximum deposit is $2,500, plus any IRS-approved cost-of-living adjustment.

» The LPFSA is limited to eligible out-of-pocket **dental and vision medical expenses only**.

» The LPFSA is available for all active full-time employees, including employees who have enrolled in the Consumer Driven health plan with the Health Savings Account (CDHP-HSA) option.

» Employees cannot participate in GPFSA and LPFSA at the same time.

» Any balance in the account after the end of the plan year, the Grace Period and the Run-Out Period will be forfeited and will not be returned to you, in accordance with the IRS "use or lose" rule.

- The Grace Period modifies the IRS "use or lose" rule. **Participants have until March 15 to incur eligible expenses to be reimbursed from unused amounts remaining at the end of the immediately preceding plan year, which ends December 31.**
- The Run-Out Period is the 45-day time period after the end of the Grace Period, during which participants can submit eligible expenses incurred during the preceding plan year and the Grace Period for reimbursement. **Eligible expenses must be received by April 29 to be paid from funds remaining at the end of the immediately preceding plan year.**

» You must **re-enroll** every year during the Flexible Benefits Annual Enrollment period to continue LPFSA participation.

Flexible Benefits Plan

Qualified Reservist Distribution (QRD)
A qualified reservist distribution (QRD) is a refund made to an employee of all or a portion of the balance remaining in the employee's unused General-Purpose Health Care Flexible Spending Arrangement (GPFSA) account or Limited-Purpose Dental/Vision Flexible Spending Arrangement (LPFSA) account. To qualify for a QRD, the individual must be a member of a military unit ordered or called to active duty for a period of 180 days or more.

Employees can make a request for distribution during the period that begins with the date they were called or ordered to active duty and ends on the last day of the Grace Period for the plan year. The amount of the distribution is limited to the amount contributed to the GPFSA or the LPFSA as of the date of the QRD request, less any GPFSA or LPFSA reimbursements and prior QRDs. QRD request forms can be downloaded online.

Flexible Benefits Plan - Dependent Care FSA
Do you earn more than $25,000 annually and pay for care of your eligible dependents while you work? If you do, then the Dependent Care Flexible Spending Arrangement could save you money.

Important information to remember:

» Your enrollment is for the Flexible Benefits Plan Year (Jan. 1 through Dec. 31, 2014) and changes can only be made when you experience a qualifying event as defined by the IRS.
» The minimum deposit is $600. The maximum deposit is $5,000.
» If you are married, filing jointly; single, head of household; or married, with a spouse incapable of self-care, your maximum contribution is $5,000. If you are single or married, filing separately, the maximum contribution is $2,500.
» Any balance in the account after the end of the plan year, the Grace Period and the Run-Out Period will be forfeited and will not be returned to you, due to the IRS "use or lose" rule.
  - The Grace Period modifies the IRS "use or lose" rule. **Participants have until March 15 to incur eligible expenses to be reimbursed from unused amounts remaining at the end of the immediately preceding plan year, which ends Dec. 31.**
  - The Run-Out Period is the 45-day time period after the end of the Grace Period, during which participants can submit eligible expenses incurred during the preceding plan year and the Grace Period for reimbursement. **Eligible expenses must be received by April 29, to be paid from funds remaining at the end of the immediately preceding plan year.**
» Employees who participate in the Dependent Care Flexible Spending Arrangement are required to pay the annual Administrative Fee.
» **You must re-enroll every year during the Flexible Benefits Annual Enrollment period to continue participation.**
» Participants who re-enroll in one of the Flexible Spending Arrangements will continue to use the same FSA card from the prior year.
» To make this option as convenient as possible, the Flexible Benefits administrator offers a Recurring Expense Service. This service pre-certifies your regularly recurring dependent care expense so you never have to keep a receipt, complete a claim form or swipe your FSA card.
» Dependent care expenses must be incurred before they can be reimbursed.
» Eligible employees who want to set aside money for dependent care expenses before taxes are calculated must complete a State of Louisiana Flexible Spending Arrangement Enrollment Form. This form is available from your human resources/payroll department or you can download the form from OGB's website. The completed form must be returned to your human resources/payroll department.
» After your payroll department enters your Dependent Care FSA information into their payroll system, they must fax a copy of your enrollment form to the Flexible Benefits administrator.
» During Annual Enrollment only, agencies **are not required** to fax the FSA Enrollment Form.

Life Insurance

OGB offers fully-insured life insurance coverage. The state pays half of the life insurance premium for covered employees and retirees.

The two plans of life insurance available, along with the corresponding amounts of dependent life insurance offered under each plan, are noted below.

Basic Life

Option 1		Option 2	
Employee	$5,000	Employee	$5,000
Spouse	$1,000	Spouse	$2,000
Each Child	$500	Each Child	$1,000
Dependent Life	Employee pays $0.98/month	Dependent Life	Employee pays $1.96/month

Basic Plus Supplemental Plan

Option 1		Option 2	
Employee	Schedule to max of $50,000*	Employee	Schedule to max of $50,000*
**Amount based on employee's annual salary*		**Amount based on employee's annual salary*	
Spouse	$2,000	Spouse	$4,000
Each Child	$1,000	Each Child	$2,000
Dependent Life	Employee pays $1.96/month	Dependent Life	Employee pays $3.92/month

Important Notes

- Newly hired employees who enroll within 30 days of employment are eligible for life insurance without providing evidence of insurability.
- Employees who enroll in the life insurance plan after 30 days are required to supply evidence of insurability to the insurer.
- Plan members currently enrolled who wish to add dependent life coverage for a spouse can do so by providing evidence of insurability. Eligible dependent children can be added without providing evidence of insurability to the insurer.
- Employee pays 100 percent of dependent life premiums.

It is important to keep your address current. Complete an address change document at your human resources department any time your residence changes.

Accidental Death and Dismemberment

Who is Eligible?

Basic and Basic Plus Supplemental Plans

- Full-Time Employees
- Eligible Retirees

Dependent Life

- Covered employee's legal spouse.
- Your children up to age 26. Effective July 1, 2011, OGB health plans will cover dependents up to age 26 regardless of student, marital or tax status.

Life Insurance

Table of Losses

Accidental Loss	Benefit	Accidental Loss	Benefit
Life	100%	Both hands or both feet	100%
One hand/one foot	100%	Sight in both eyes	100%
One hand/sight in one eye	100%	One foot/sight in one eye	100%
Speech/hearing in both ears	100%	Quadriplegia	100%
Paraplegia	75%	One hand	50%
One foot	50%	Sight in one eye	50%
Hemiplegia	50%	Speech	50%
Hearing in both ears	50%	Thumb & index finger/same hand	50%

Continued Coverage for Dependent Children

A covered child under age 26 who is or becomes incapable of self-sustaining employment is eligible to continue coverage as an overage dependent if OGB receives required medical documents verifying his or her incapacity before he or she reaches age 26. The definition of incapacity has been broadened to include mental and physical incapacity.

Plan Changes at Age 65 and Age 70

Plan members enrolled in life insurance coverage will automatically have 25 percent reduced coverage on January 1 following their 65th birthday. Another automatic 25 percent reduction in coverage will take effect on January 1 following their 70th birthday. Premium rates will be reduced accordingly.

Portability

Terminated employees can take advantage of the portability provision and continue coverage at group rates. Such coverage will be at a higher rate, and the state will not contribute any portion of the premium. The insurer will determine premium rates. You do not need to submit an evidence of insurability form to continue coverage. You can apply for portability through the plan member's agency. The insurer must receive the application no later than 31 days from the date employment terminates. You may be eligible for preferred group rates. You must complete an evidence of insurability form and submit it to the insurer to find out if you are eligible for preferred rates.

Accidental Death and Dismemberment Benefits

If retired, coverage for accidental death and dismemberment automatically terminates on January 1 following the covered person's 70th birthday. If the plan member is still actively employed at age 70, coverage terminates at midnight on the last day of the month in which retirement occurs.

Death Notification

Please notify the human resources office at the plan member's agency (or former agency, if retired) when a plan member or covered dependent dies. A certified copy of the death certificate must be provided to the plan member's agency.

Basic and Supplemental Life Insurance Schedule

For Active and Retired Employees under Age 65

Schedule 1 effective January 1, 2013

Includes Accidental Death & Dismemberment (AD&D)*

	ANNUAL EARNINGS**	MAXIMUM INSURANCE	TOTAL PREMIUM WITH AD&D***	EMPLOYEE SHARE
BASIC LIFE:		$ 5,000	$ 5.40	$ 2.70
BASIC AND SUPPLEMENTAL LIFE:	$ 2,000.01 - 2,666.66	$ 6,000	$ 6.48	3.24
	2,666.67 - 3,333.33	7,000	7.56	3.78
	3,333.34 - 4,000.00	8,000	8.64	4.32
	4,000.01 - 4,666.66	9,000	9.72	4.86
	4,666.67 - 5,333.33	10,000	10.80	5.40
	5,333.34 - 6,000.00	11,000	11.88	5.94
	6,000.01 - 6,666.66	12,000	12.96	6.48
	6,666.67 - 7,333.33	13,000	14.04	7.02
	7,333.34 - 8,000.00	14,000	15.12	7.56
	8,000.01 - 8,666.66	15,000	16.20	8.10
	8,666.67 - 9,333.33	16,000	17.28	8.64
	9,333.34 - 10,000.00	17,000	18.36	9.18
	10,000.01 - 10,666.66	18,000	19.44	9.72
	10,666.67 - 11,333.33	19,000	20.52	10.26
	11,333.34 - 13,333.33	20,000	21.60	10.80
	13,333.34 - 14,000.00	21,000	22.68	11.34
	14,000.01 - 14,666.66	22,000	23.76	11.88
	14,666.67 - 15,333.33	23,000	24.84	12.42
	15,333.34 - 16,000.00	24,000	25.92	12.96
	16,000.01 - 16,666.66	25,000	27.00	13.50
	16,666.67 - 17,333.33	26,000	28.08	14.04
	17,333.34 - 18,000.00	27,000	29.16	14.58
	18,000.01 - 18,666.66	28,000	30.24	15.12
	18,666.67 - 19,333.33	29,000	31.32	15.66
	19,333.34 - 20,000.00	30,000	32.40	16.20
	20,000.01 - 20,666.66	31,000	33.48	16.74
	20,666.67 - 21,333.33	32,000	34.56	17.28
	21,333.34 - 22,000.00	33,000	35.64	17.82
	22,000.01 - 22,666.66	34,000	36.72	18.36
	22,666.67 - 23,333.33	35,000	37.80	18.90
	23,333.34 - 24,000.00	36,000	38.88	19.44
	24,000.01 - 24,666.66	37,000	39.96	19.98
	24,666.67 - 25,333.33	38,000	41.04	20.52
	25,333.34 - 26,000.00	39,000	42.12	21.06
	26,000.01 - 26,666.00	40,000	43.20	21.60
	26,666.01 - 27,333.33	41,000	44.28	22.14
	27,333.34 - 28,000.00	42,000	45.36	22.68
	28,000.01 - 28,666.66	43,000	46.44	23.22
	28,666.67 - 29,333.33	44,000	47.52	23.76
	29,333.34 - 30,000.00	45,000	48.60	24.30
	30,000.01 - 30,666.66	46,000	49.68	24.84
	30,666.67 - 31,333.33	47,000	50.76	25.38
	31,333.34 - 32,000.00	48,000	51.84	25.92
	32,000.01 - 32,666.66	49,000	52.92	26.46
	32,666.67 and above	50,000	54.00	27.00

* Accidental Death & Dismemberment benefits are included for all active and retired employees who are under the age of 65.

** Annual Earnings for those academic employees who work fewer than 12 months of the calendar year shall be the salary for that period of time required by their regular job duties as defined at the beginning of the academic year. For retired employees, "annual earnings" means that salary level for which benefits were provided as an active employee on the last day of the month immediately preceding the actual last day of work.

*** Total includes both state and employee shares of the premium.

Basic and Supplemental Life Insurance Schedule

For Active and Retired Employees Ages 65 through 69

Schedule 2 effective January 1, 2013

Includes Accidental Death & Dismemberment (AD&D)*

	ANNUAL EARNINGS**	MAXIMUM INSURANCE	TOTAL PREMIUM WITH AD&D***	EMPLOYEE SHARE
BASIC LIFE:		$ 4,000	$ 4.32	$ 2.16
BASIC AND SUPPLEMENTAL LIFE:	$ 2,000.01 - 2,666.66	$ 5,000	$ 5.40	$ 2.70
	2,666.67 - 4,000.00	6,000	6.48	3.24
	4,000.01 - 4,666.66	7,000	7.56	3.78
	4,666.67 - 5,333.33	8,000	8.64	4.32
	5,333.34 - 6,666.66	9,000	9.72	4.86
	6,666.67 - 7,333.33	10,000	10.80	5.40
	7,333.34 - 8,000.00	11,000	11.88	5.94
	8,000.01 - 9,333.33	12,000	12.96	6.48
	9,333.34 - 10,000.00	13,000	14.04	7.02
	10,000.01 - 10,666.66	14,000	15.12	7.56
	10,666.67 - 13,333.33	15,000	16.20	8.10
	13,333.34 - 14,000.00	16,000	17.28	8.64
	14,000.01 - 14,666.66	17,000	18.36	9.18
	14,666.67 - 16,000.00	18,000	19.44	9.72
	16,000.01 - 16,666.66	19,000	20.52	10.26
	16,666.67 - 17,333.33	20,000	21.60	10.80
	17,333.34 - 18,666.66	21,000	22.68	11.34
	18,666.67 - 19,333.33	22,000	23.76	11.88
	19,333.34 - 20,000.00	23,000	24.84	12.42
	20,000.01 - 21,333.33	24,000	25.92	12.96
	21,333.34 - 22,000.00	25,000	27.00	13.50
	22,000.01 - 22,666.66	26,000	28.08	14.04
	22,666.67 - 24,000.00	27,000	29.16	14.58
	24,000.01 - 24,666.66	28,000	30.24	15.12
	24,666.67 - 25,333.33	29,000	31.32	15.66
	25,333.34 - 26,666.66	30,000	32.40	16.20
	26,666.67 - 27,333.33	31,000	33.48	16.74
	27,333.34 - 28,000.00	32,000	34.56	17.28
	28,000.01 - 29,333.33	33,000	35.64	17.82
	29,333.34 - 30,000.00	34,000	36.72	18.36
	30,000.01 - 30,666.66	35,000	37.80	18.90
	30,666.67 - 32,000.00	36,000	38.88	19.44
	32,000.01 - 32,666.66	37,000	39.96	19.98
	32,666.67 and above	38,000	41.04	20.52

* Accidental Death & Dismemberment benefits are included for all active and retired employees who are age 65 through age 69.

** Annual Earnings for those academic employees who work fewer than 12 months of the calendar year shall be the salary for that period of time required by their regular job duties as defined at the beginning of the academic year. For retired employees, "annual earnings" means that salary level for which benefits were provided as an active employee on the last day of the month immediately preceding the actual last day of work.

*** Total includes both state and employee shares of the premium.

Basic and Supplemental Life Insurance Schedule

For Active Employees Age 70 and Over

Schedule 3 effective January 1, 2013

Includes Accidental Death & Dismemberment (AD&D)*

	ANNUAL EARNINGS**	MAXIMUM INSURANCE	TOTAL PREMIUM WITH AD&D***	EMPLOYEE SHARE
BASIC LIFE:		$ 3,000	$ 3.24	$ 1.62
BASIC AND SUPPLEMENTAL LIFE:	$ 2,666.67 - 4,000.00	$ 4,000	$ 4.32	$ 2.16
	4,000.01 - 5,333.33	5,000	5.40	2.70
	5,333.34 - 6,666.66	6,000	6.48	3.24
	6,666.67 - 8,000.00	7,000	7.56	3.78
	8,000.01 - 9,333.33	8,000	8.64	4.32
	9,333.34 - 10,666.66	9,000	9.72	4.86
	10,666.67 - 13,333.33	10,000	10.80	5.40
	13,333.34 - 14,666.66	11,000	11.88	5.94
	14,666.67 - 16,000.00	12,000	12.96	6.48
	16,000.01 - 17,333.33	13,000	14.04	7.02
	17,333.34 - 18,666.66	14,000	15.12	7.56
	18,666.67 - 20,000.00	15,000	16.20	8.10
	20,000.01 - 21,333.33	16,000	17.28	8.64
	21,333.34 - 22,666.66	17,000	18.36	9.18
	22,666.67 - 24,000.00	18,000	19.44	9.72
	24,000.01 - 25,333.33	19,000	20.52	10.26
	25,333.34 - 26,666.66	20,000	21.60	10.80
	26,666.67 - 28,000.00	21,000	22.68	11.34
	28,000.01 - 29,333.33	22,000	23.76	11.88
	29,333.34 - 30,666.66	23,000	24.84	12.42
	30,666.67 - 32,000.00	24,000	25.92	12.96
	32,000.01 and above	25,000	27.00	13.50

* Accidental Death & Dismemberment benefits are included for all active employees who are age 70 and over.

** Annual Earnings for those academic employees who work fewer than 12 months of the calendar year shall be the salary for that period of time required by their regular job duties as defined at the beginning of the academic year. For retired employees, "annual earnings" means that salary level for which benefits were provided as an active employee on the last day of the month immediately preceding the actual last day of work.

*** Total includes both state and employee shares of the premium.

Basic and Supplemental Life Insurance Schedule

For Retired Employees Age 70 and Over

Schedule 4 effective January 1, 2013

Accidental Death & Dismemberment (AD&D) not included for retired employees age 70 and over*

	ANNUAL EARNINGS**	MAXIMUM INSURANCE	TOTAL PREMIUM WITH AD&D***	EMPLOYEE SHARE	
BASIC LIFE:		$ 3,000	$ 3.12	$ 1.56	
BASIC AND SUPPLEMENTAL LIFE:	$ 2,666.67 - 4,000.00	$ 4,000	$ 4.16	$ 2.08	
	4,000.01 - 5,333.33	5,000	5.20		2.60
	5,333.34 - 6,666.66	6,000	6.24		3.12
	6,666.67 - 8,000.00	7,000	7.28		3.64
	8,000.01 - 9,333.33	8,000	8.32		4.16
	9,333.34 - 10,666.66	9,000	9.36		4.68
	10,666.67 - 13,333.33	10,000	10.40	5.20	
	13,333.34 - 14,666.66	11,000	11.44	5.72	
	14,666.67 - 16,000.00	12,000	12.48	6.24	
	16,000.01 - 17,333.33	13,000	13.52	6.76	
	17,333.34 - 18,666.66	14,000	14.56	7.28	
	18,666.67 - 20,000.00	15,000	15.60	7.80	
	20,000.01 - 21,333.33	16,000	16.64	8.32	
	21,333.34 - 22,666.66	17,000	17.68	8.84	
	22,666.67 - 24,000.00	18,000	18.72	9.36	
	24,000.01 - 25,333.33	19,000	19.76	9.88	
	25,333.34 - 26,666.66	20,000	20.80	10.40	
	26,666.67 - 28,000.00	21,000	21.84	10.92	
	28,000.01 - 29,333.33	22,000	22.88	11.44	
	29,333.34 - 30,666.66	23,000	23.92	11.96	
	30,666.67 - 32,000.00	24,000	24.96	12.48	
	32,000.01 and above	25,000	26.00	13.00	

* Accidental Death & Dismemberment benefits are dropped on all retired employees on the July 1 following retirement and attainment of age 70.

** Annual Earnings for those academic employees who work fewer than 12 months of the calendar year shall be the salary for that period of time required by their regular job duties as defined at the beginning of the academic year. For retired employees, "annual earnings" means that salary level for which benefits were provided as an active employee on the last day of the month immediately preceding the actual last day of work.

*** Total includes both state and employee shares of the premium.

Subrogation and Reimbursement

Upon payment of any eligible Benefits covered under this Plan, the Office of Group Benefits shall succeed and be subrogated to all rights of recovery of the covered Employee, his Dependents or other Covered Persons, or their heirs or assigns, for whose benefit payment is made, and they shall execute and deliver instruments and papers and do whatever is necessary to secure such rights, and shall do nothing after loss to prejudice such rights.

The Office of Group Benefits has an automatic lien against and shall be entitled, to the extent of any payment made to a covered Employee, his Dependents or other Covered Persons, to 100% of the proceeds of any settlement or judgment that may result from the exercise of any rights of recovery of a covered Employee, his Dependents or other Covered Persons, against any person or entity legally responsible for the disease, illness, accident or injury for which said payment was made.

To this end, covered Employees, their Dependents, or other Covered Persons agree to immediately notify the Office of Group Benefits of any action taken to attempt to collect any sums against any person or entity responsible for the disease, illness, accident or injury.

These subrogation and reimbursement rights also apply when a Covered Person recovers under, but not limited to, an uninsured or underinsured motorist plan, homeowner's plan, renter's plan, medical malpractice plan, worker's compensation plan or any general liability plan.

Under these subrogation and reimbursement rights, the Office of Group Benefits has a right to first recovery to the extent of any judgment, settlement, or any payment made to the covered Employee, his Dependents or other Covered Persons. These rights apply regardless of whether such recovery is designated as payment for, but not limited to, pain and suffering, medical benefits, or other specified damages, even if he is not made whole (i.e., fully compensated for his injuries).

The subrogation and reimbursement rule applies to OGB plan members in OGB self-funded PPO and HMO health plans.

Information regarding subrogation and reimbursement for all OGB health plans shall be forwarded to or obtained from:

Legal Division
Office of Group Benefits
P.O. Box 44036
Baton Rouge, LA 70804

SubroLaw@la.gov

(225) 925-7739

In Health: Blue Health Disease Management Program

The In Health: Blue Health Disease Management Program makes health coaches available to OGB plan members who have been diagnosed with one or more of these five ongoing health conditions—diabetes, heart disease, heart failure, asthma or chronic obstructive pulmonary disease (COPD). Health coaches are specially trained health professionals who can offer health information and support and help you work with your doctor to manage your health.

The In Health: Blue Health Disease Management Program is available at no additional cost to OGB plan members who:

- are enrolled in the OGB PPO, or HMO plan;
- do not have Medicare Part A and/or Part B as their primary health coverage; and
- have been diagnosed with diabetes, heart disease, heart failure, asthma or chronic obstructive pulmonary disease (COPD).

OGB encourages eligible plan members to enroll and participate. Once you receive a welcome packet, you can call a health coach any time toll-free at (800) 383-0115 for information and support regarding any health concerns or questions you have.

The program offers:

- **Personal, caring service around the clock**
- You will receive responsive, caring service from a In Health: Blue Health Disease Management Program health coach, personalized to meet your specific health care needs.
- **Online health information and resources**

In Health: Blue Health Disease Management Program participants are eligible for OGB's prescription drug incentive. As long as you remain an active participant in the In Health: Blue Health Disease Management Program, OGB will waive the standard $1,200 out-of-pocket maximum on covered prescription drugs for the treatment of diabetes, heart disease, heart failure, asthma or chronic obstructive pulmonary disease (COPD). This means you will pay a reduced co-payment of $15 for brand name drugs (when a generic is not available) or $0 for generic drugs for a 31-day supply of medication used to treat one or more of these five conditions with which you have been diagnosed.

However, covered prescription drugs NOT used to treat one of the five diagnosed health conditions above will continue to be subject to the standard prescription benefit (50 percent co-insurance up to a maximum of $50 per prescription per 31-day supply and the standard $1,200 maximum out-of-pocket expense per plan year).

Active participation involves an ongoing relationship with In Health: Blue Health Disease Management Program health coaches that includes an initial assessment and follow-up contacts via phone, mail and email for support and information to help you manage your health condition(s). As a participant in the In Health: Blue Health Disease Management Program, it is your responsibility to maintain a continuing relationship with In Health: Blue Health Disease Management Program health coaches. If you fail to interact with a health coach at least once every three months, or if Medicare Part A and/or Part B become your primary health coverage, you will no longer be eligible to participate in the In Health: Blue Health Disease Management Program or receive the reduced co-pay on your applicable prescription drugs.

If you have any questions or need additional information, contact a In Health: Blue Health Disease Management Program health coach toll-free at (800) 363-9159.

Important Phone Numbers and Information

Refer to your plan's identification card to obtain phone numbers for the following:

- Pre-Certification, Outpatient Pre-Certification and Continued Stay Review (PAC, OPC, CSR)
- Prescription Benefit Management (PBM)
- Mental Health/Substance Abuse Treatment /Therapy (MH/SA)

OGB Customer Service Offices

As always, the Office of Group Benefits continues to oversee all OGB-sponsored health plans – the self-insured PPO plan, HMO plan and Consumer-Driven health plan, or CDHP, (administered by Blue Cross); the fully-insured Medical Home HMO plan (administered by Vantage); and the fully-insured Medicare Advantage HMO plans (administered by Peoples Health and by Vantage). Questions about health coverage continue to be directed to the health plan in which the member is enrolled.

For information about health plan benefits, pre-authorization, claims or payments:

PPO/HMO/ CDHP	Blue Cross	800-392-4089
Medical Home HMO/ Vantage Medicare Advantage HMO/ Vantage $0 Premium Medicare Advantage HMO	Vantage	888-823-1910 318-361-0900
Peoples Health Medicare Advantage HMO	Peoples Health	866-912-8304
Individual Medicare Plan (HRA)	ExtendHealth	855-663-4228

Claim Filing Deadline

Claims for services must be filed within one year of the date of service. No benefits are payable for claims received after the deadline. Keep in mind, it is not the date of mailing that determines the timeliness; it is the date the claim is received by your plan.

Finding a Provider in Your Network

A current listing of network providers for each OGB health plan is accessible online any time on the OGB website **(www.groupbenefits.org)** by clicking on Health Plans under Quic k Links.

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